



Medical Records Release Form

PATIENT INFORMATION

- **Patient Name:** _____
- **Date of Birth:** _____ **Phone:** _____

AUTHORIZATION TO RELEASE RECORDS

I hereby authorize the release of my personal health information during the term of this authorization to the recipient(s) identified below:

- **Release From (Name/Facility):** _____
- **Release To (Recipient Name):** _____
- **Recipient Address:** _____
- **City / State / Zip:** _____
- **Fax Number:** _____ **Phone:** _____

RECORDS TO BE RELEASED *Please check the desired option:*

- ☐ **All Health Information:** Includes all medical history, mental/physical conditions, and treatments in the provider's possession.
- ☐ **Limited Records Only:** *(Please specify)* _____

Purpose of Release: _____

(Note: "At the request of the patient" is sufficient if initiated by the patient)

TERMS & SIGNATURE

- This authorization will remain in effect from the date signed until: ____ day of _____, 20____
- *I understand that I may revoke this authorization at any time by sending a written request to Eye Disease Consultants at the address below, except to the extent that action has already been taken in reliance on it.*
- *I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.*
- *I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party not bound by federal/state privacy laws.*
- *I understand that I am entitled to a copy of this signed authorization.*

• **Patient/Authorized Signature:** _____ **Date:** _____

• *If signed by a parent, legal guardian, or responsible party, please print name and state relationship:*

Name: _____ Relationship: _____

• **Witness Signature:** _____ **Date:** _____